

**Montana Medicaid and Mental Health Services Plan  
Acute Inpatient Hospitalization/Residential Treatment Care  
For Individuals under 21**

**CERTIFICATE OF NEED**

**Check One: Acute Inpatient: (Medicaid only)** ☐ **Residential Treatment Center:** ☐

Recipient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Medicaid/MHSP ID Number: \_\_\_\_\_

Admitting Facility: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Proposed Admission Date: \_\_\_\_\_ Expected Discharge Date: \_\_\_\_\_

**At the time of admission the interdisciplinary team certifies the following:**

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient; (include documentation)  
\_\_\_\_\_  
\_\_\_\_\_
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; (include documentation)  
\_\_\_\_\_  
\_\_\_\_\_
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. (include documentation)  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print/Type Name of Physician Team Member Title

\_\_\_\_\_  
Signature of Physician Team Member Date

\_\_\_\_\_  
Print/Type Name of Mental Health Professional Title

\_\_\_\_\_  
Signature of Mental Health Professional Date

\_\_\_\_\_  
Print/Type Name of Case Manager **(Required for RTC only)** Mental Health Center

\_\_\_\_\_  
Signature of Case Manager Date Telephone Number